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8	REFO	RE THE	
9	BOARD OF REGISTERED NURSING DEPARTMENT OF CONSUMER AFFAIRS		
10	STATE OF CALIFORNIA		
11	In the Matter of the Accusation Against:	Case No. 2012 - 80	
12	JUDITH MARY BURTON, AKA JUDY	ACCUSATION	
13	BURTON P.O. Box 8723		
14	Goleta, CA 93118 Registered Nurse License No. 481031		
15	Respondent.		
16			
17	Complainant alleges:		
18	<u>PARTIES</u>		
19	1. Louise R. Bailey, M.Ed., R.N. (Complainant) brings this Accusation solely in her		
20	official capacity as the Executive Officer of the Board of Registered Nursing (Board),		
21	Department of Consumer Affairs.		
22	2. On or about August 31, 1992, the Board issued Registered Nurse License Number		
23	481031 to Judith Mary Burton, aka Judy Burton (Respondent). The Registered Nurse License		
24	was in full force and effect at all times relevant to the charges brought herein and will expire on		
25	January 31, 2012, unless renewed.		
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JURISDICTION

- 3. This Accusation is brought before the Board under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.
- 4. Section 118, subdivision (b) of the Code provides that the suspension/expiration/surrender/cancellation of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary action during the period within which the license may be renewed, restored, reissued or reinstated.
- 5. Section 2750 of the Code provides that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.
- 6. Section 2764 of the Code provides that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811, subdivision (b) of the Code, the Board may renew an expired license at any time within eight years after the expiration.

STATUTORY AND REGULATORY PROVISIONS

- 7. Section 490 of the Code provides that a board may suspend or revoke a license on the ground that the licensee has been convicted of a crime substantially related to the qualifications, functions, or duties of the business or profession for which the license was issued.
 - 8. Section 493 of the Code states, in pertinent part:

"Notwithstanding any other provision of law, in a proceeding conducted by a board within the department pursuant to law . . . to suspend or revoke a license or otherwise take disciplinary action against a person who holds a license, upon the ground that . . . the licensee has been convicted of a crime substantially related to the qualifications, functions, and duties of the licensee in question, the record of conviction of the crime shall be conclusive evidence of the fact that the conviction occurred, but only of that fact, and the board may inquire into the circumstances surrounding the commission of the crime in order to fix the degree of discipline or to determine if the conviction is substantially related to the qualifications, functions, and duties of the licensee in question."

9. Section 2761 of the Code states, in pertinent part:

"The board may take disciplinary action against a . . . licensed nurse . . . for any of the following:

- "(a) Unprofessional conduct, which includes, but is not limited to, the following:
- "(1) Incompetence, or gross negligence in carrying out usual... licensed nursing functions.

. . .

"(d) Violating or attempting to violate, directly or indirectly, . . . any provision or term of this chapter [the Nursing Practice Act] or regulations adopted pursuant to it.

. . .

- "(f) Conviction of a felony or of any offense substantially related to the qualifications, functions, and duties of a registered nurse, in which event the record of the conviction shall be conclusive evidence thereof."
 - 10. Section 2762 of the Code states, in pertinent part:

"In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:

. . .

- "(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section."
- 11. California Code of Regulations, title 16, section 1442, defines the term "gross negligence," as used in Code section 2761, as "includ[ing] an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life."

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- California Code of Regulations, title 16, section 1443, defines the term 12. "incompetence," as used in Code section 2761, as "mean[ing] the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5."
 - California Code of Regulations, title 16, section 1443.5 states, in pertinent part:

"A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

- "(3) Performs skills essential to the kind of nursing action to be taken "
- California Code of Regulations, title 16, section 1444, states, in pertinent part:

"A conviction or act shall be considered to be substantially related to the qualifications, functions or duties of a registered nurse if to a substantial degree it evidences the present or potential unfitness of a registered nurse to practice in a manner consistent with the public health, safety, or welfare. Such convictions or acts shall include but not be limited to the following:

"(c) Theft, dishonesty, fraud, or deceit."

Section 125.3 of the Code provides, in pertinent part, that the Board may request the 15. administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

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FIRST CAUSE FOR DISCIPLINE

REASONABLE COSTS

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(Gross Negligence and/or Incompetence)

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Respondent is subject to disciplinary action under Code section 2761, subdivision (a)(1) in that Respondent engaged in gross negligence and/or incompetence while employed as a registered nurse at Santa Barbara Cottage Hospital. The circumstances are as follows:

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- a. On or about July 11, 2009, while Respondent was working the night shift,
 Respondent failed to comply with a doctor's order for straight catheterization of a patient, who
 was last catheterized by the day shift registered nurse at 12:00 noon, and who had a doctor's order
 for straight catheterization every six (6) hours. Per the doctor's order, Respondent was required
 to catheterize the patient at 6 p.m., but did not catheterize the patient until at or about 11:30 p.m.
- b. On or about July 13, 2009, a doctor's written order was made for a patient for 5 milligrams of Ambien as follows: "Ambien 5 mg PO prn insomnia." The order was then clarified on the same page as "Ambien 5 mg po QHS prn insomnia," which means to give Ambien orally every night as needed for sleep. On the Medication Administration Record (MAR) for July 13 through July 14, 2009, Respondent erroneously transcribed the doctor's Ambien order as "300 mgm po QHS prn," and she signed off giving the medication at 2125 (i.e., 8:25 p.m.). The AcuDose-Rx® Activity Report indicates that Respondent dispensed 5 milligrams of Zolpidem, a prescription medication whose trade names include Ambien.
- c. On or about July 13 and July 14, 2009, Respondent had 2 patients with doctors' orders for the same doses of the antibiotic Rocephin IV. Respondent gave each patient the wrong bag of medication.
- d. On or about July 16, 2009, at about 1800 or 6 p.m., Respondent failed to comply with the doctor's order of hanging a tube feeding for a patient. This failure was discovered at around 2300 or 11 p.m.
- e. On or about July 16, 2009, Respondent failed to comply with a doctor's order at 1500 or 3 p.m. to start 250 milligrams of intravenous Daptomycin every 24 hours "asap" or as soon as possible. According to the MAR, the Daptomycin was not given until about 2100 or 9 p.m. When this failure was discovered around 2300 or 11 p.m., Respondent said she would give the drug orally, but the Daptomycin was still in the medication room and the pharmacy did not dispense an oral dose because the medication was ordered every 24 hours. Respondent's failure to dispense the medication required the subject patient to be hospitalized an extra day.

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SECOND CAUSE FOR DISCIPLINE

(Unprofessional Medical Documentation)

- 17. Respondent is subject to disciplinary action under Code section 2762, subdivision (e) in that Respondent engaged in inaccurate medical documentation, failed to provide any documentation, failed to provide complete documentation, and falsified a medical record. The circumstances are as follows:
- a. On or about July 5, 2009, 1.5 milligrams of Dilaudid were unaccounted for in Respondent's narcotics administration records.
- b. On or about July 13, 2009, Respondent inaccurately transcribed a doctor's order for 5 milligrams of Ambien for a patient. Respondent transcribed the order as 300 milligrams of Ambien.
- c. On or about July 13, 2009, 2 of Respondent's 4 assigned patients had no medical documentation, and 2 had only partial documentation.
- d. On or about July 13, 2009, a total of 5 milligrams of Morphine and 5 milligrams of Ambien were unaccounted for in Respondent's narcotics administration records.
- e. On or about July 16, 2009, Respondent falsified a medical record of a patient who a doctor ordered to be given 250 milligrams if intravenous Daptomycin every 24 hours. After another registered nurse confronted Respondent as to her failure to comply with the doctor's order, Respondent signed off that she gave the medication orally, even though the pharmacy did not dispense an oral dose because the medication was ordered every 24 hours.
- f. On or about July 16, 2009, 1 milligram of Dilaudid was dispensed to patient MR 597177 at approximately 1933 or 7:33 p.m. with a documented pain scale of zero or 0/10 at 1930 or 7:30 p.m., with zero being no pain and ten being the most severe pain.
- g. On or about July 18, 2009, Norco was dispensed to patient MR 727175 at approximately 2223 or 10:23 p.m. with a documented pain scale of zero at 2200 or 10:00 p.m.
- h. On or about July 19, 2009, a total of 5 milligrams of Oxycodone were unaccounted for in Respondent's narcotics administration records.

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a. On or about December 15, 2009, in *People v. Burton* (Super. Ct. Santa Barbara County, 2009, No. 1299382), Respondent pleaded no contest to and was convicted of misdemeanor theft, in violation of Penal Code section 484, subdivision (a), and she was sentenced to three years' criminal probation with terms including obeying all laws. The basis of the conviction was that on or about August 30, 2009, Respondent stole approximately \$472.81 in merchandise from a Kmart store in Goleta City.

FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

- 19. Respondent is subject to disciplinary action under Code section 2761, subdivisions (a) and (d) in that Respondent engaged in unprofessional conduct, and violated statutory provisions of the Nursing Practice Act and/or regulations adopted pursuant to the Nursing Practice Act. The circumstances are alleged in paragraphs 16 through 18, subparagraph (a), above, inclusive, and are incorporated by reference as though fully set forth therein. In addition, Respondent engaged in the following unprofessional conduct.
- a. As of on or about August 27, 2009, Respondent had been tardy for 40 of her last 56 shifts, and had been up to 39 minutes late.
 - b. On or about July 23, 2009, Respondent violated Santa Barbara Cottage Hospital's code

of conduct by being verbally loud to the charge nurse and slamming items on the nurse's station desk. Because of Respondent's disruptive conduct, she had to be asked to go into a different room.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 481031, issued to Respondent Judith Mary Burton, aka Judy Burton;

1	2. Ordering Respondent to pay the Board the reasonable costs of the investigation	tion and	
2	enforcement of this case, pursuant to Code section 125.3; and		
3	3. Taking such other and further action as deemed necessary and proper.		
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6	DATED: Angust 8, 2011 Strue Ben		
7	LOUISE R. BAILEY, M.ED., RN		
8	Executive Officer Board of Registered Nursing		
9	Department of Consumer Affairs State of California	•	
10	Complainant		
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